UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

IN RE BEXTRA AND CELEBREX MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	Master Docket No. M:05-CV-01699-CRB MDL No. 1699
THIS RELATES TO: MDL Case No. _____	Plaintiff: William M. Griffin (name)

BEXTRA®
PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered personal injury as a result of taking BEXTRA® (but no CELEBREX®) must complete this Fact Sheet. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. Please attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Name of person completing this form: William M. Griffin

B. Please state the following for the civil action that you filed:

1. Case caption: William M. Griffin, Widower, and as Personal Representative of the Estate of Shirley Griffin, deceased

2. Civil Action Number: 5:06-cv-00075

3. Court in which action was originally filed: Southern District of Georgia

4. Your attorney:

   Name: Donald F. Black, Esquire

   Firm: Harrell & Harrell, P.A.

   Address: 4735 Sunbeam Road, Jacksonville, FL 32257

   Telephone Number: 904-251-1111 Fax Number: 904-251-1110

   E-mail Address: dblack@251-1111.com

C. If you are completing this Fact Sheet in a representative capacity (e.g. on behalf of the estate of a deceased person or a minor), please complete the following:

1. Maiden or other names you have used or by which you have been known and dates you used those names:

William Mathew Griffin

2. Current Address: 3852 Valdosta Hwy, Waycross, GA 31503

3. State which individual or estate you are representing, and in what capacity you are representing the individual or estate:

Individual/Estate Representing: Shirley Griffin

Capacity: Widower and as Personal Representative

4. If you were appointed as a representative by a court, state the:

Court That Appointed You: _____

Date of Appointment: _____

5. What is your relationship to the individual you represent? Spouse

6. If you represent a decedent's estate, state:

Date of Death: November 26, 2004

Address of Place Where Decedent Died: 3852 Valdosta Hwy, Waycross, GA 31503

7. If you are claiming the wrongful death of a family member, identify any and all heirs of that person:

Sylvia J. Curl; William Derrick Griffin; Darryl Mathew Griffin

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED BEXTRA®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE BEXTRA® USER.

II. CLAIM INFORMATION

A. Do you claim that you suffered bodily injury as a result of taking BEXTRA®?

Yes _X_ **No** _ If **Yes**, please answer the following:

1. What bodily injury do you claim resulted from your use of BEXTRA®?

Skin rash; heart condition blood clots and death

2. When did this injury occur? November 17, 2004

3. Who diagnosed it? I do not remember

4. Were you hospitalized? Yes

Yes __ **No** __ If **Yes**, please provide the following information:

a. Date of hospital admission: November 17, 2004

b. Date of discharge: November 22, 2004

c. Hospital name and address: Satilla Regional Medical Center, 410 Darling Avenue, Waycross, GA 31501 and then was transferred to St. Vincent's Medical Center, 1800 Barrs Street, Jacksonville, Florida 32204

5. What damages do you claim you suffered as a result of your injury?

Had to have stent implanted and had blood clots

B. Do you claim that your use of BEXTRA® worsened a previously existing injury or condition?

Yes X **No** __ If **Yes**, set forth the injury of condition, whether or not you had already recovered from that injury or condition before you took BEXTRA®, and, if so, the date you previously recovered from the injury or condition:

Had breathing problems

C. Are you claiming mental and/or emotional damages as a result of taking BEXTRA®?

Yes X **No** __ If **Yes**, what mental and/or emotional damages do you claim resulted from your use of BEXTRA®?

Quality of life lessened. Not able to go and things as before

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

Name	Address	Condition treated	Dates treated	Medications prescribed
Dr. Nirmala Amaram	302 Uvalda Street, Waycross, GA	Nervousness	Do not recall	Zanax

D. Are you making a claim for lost wages or lost earning capacity?

Yes ___ **No** X If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

_____

_____

_____

III. PERSONAL INFORMATION

A. Name: Shirley Ann Griffin

B. Maiden or other names you have used or by which you have been known and dates you used those names:

Shirley Ann Cox

C. Current Address: 3852 Valdosta Hwy, Waycross, GA 31503 (prior to death)

D. Social Security Number: 256-64-2217

E. Date and Place of Birth: July 25, 1945; Hahira, GA

F. Gender: Male _____ Female X

G. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence
3852 Valdosta Hwy, Waycross, GA 31501	Lived there for 50 years

H. Schools attended:

Institution	Dates Attended	Course of Study	Diplomas or Degrees
Wacoma	1958	Elementary	Diploma

I. Employment Information: Identify the following for each employer you have had in the last ten (10) years:

Name	Address	Dates of Employment	Occupation/Job Duties
Has not worked in 20 years			

J. Military Service: Have you ever served in the military, including the military reserve or National Guard?

Yes ___ **No** X_ If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition?

Yes ___ **No** ___ If **Yes**, state the condition for which you were rejected or discharged:

_____

K. Insurance / Claim Information

1. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf since January 1, 1998 through the present?

   Yes X_ **No** ___ If **Yes**, please complete the following:

Name of Company	Address
Blue Cross Blue Shield of GA	P.O. Box 9282, Oxnard, CA 93031-9282

2. Have you ever filed a workers' compensation and/or social security disability (SSI or SSD) claim?

Yes X **No** ___ If **Yes**, please state the following:

Type of Claim	Year Claim Filed	Agency Where Claim Filed	Nature of Disability	Period of Disability
SSD	1990 or 1991	Waycross GA	Carpal tunnel	Indefinite

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes ___ **No** X If **Yes**, please state the following:

Party You Sued/ Made Claim Against	Court in Which Suit Filed/ Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

L. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ___ **No** X If **Yes**, please state the following:

1. Where convicted: _____

2. When convicted: _____

3. Nature of felony and/or crime: _____

IV. FAMILY INFORMATION

A. Marriage(s)

1. If you are or have ever been married, identify the following:

Spouse's Name	Date of Birth	Date Married	Date of End of Marriage	Reason for End of Marriage
William M. Griffin	09-27-39	12-09-1960	11-26-2004	death

2. Has your spouse filed a claim for loss of consortium in this action?

Yes __ **No** _X__

B. If you have children, please identify each child's name and date of birth.

Sylvia J. Curl, October 6, 1961; Darryl M. Griffin, July 30, 1965; William D. Griffin, November 19, 1970

C. To the best of your knowledge, has **any family member** (child, parent, sibling, or grandparent) ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart.

Condition Experienced by Family Member	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		X
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		X
3. Arteriosclerosis/hardening of the arteries/stenosis		X
4. Arthritis (osteoarthritis or rheumatoid arthritis)		X
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		X
6. Bleeding or clotting disorders		X
7. Cardiomyopathy/enlarged heart		X
8. Chest pain/angina		X
9. Chronic obstructive pulmonary disease/COPD/chronic lung disease		X
10. Congenital heart abnormality or condition		X
11. Congestive heart failure		X
12. Deep vein thrombosis/DVT		X
13. Dermatologic diseases or conditions		X
14. Diabetes	X	
15. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)	X	
16. Heart attack/MI/myocardial infarction		X
17. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		X
18. High blood pressure/hypertension	X	
19. High cholesterol or triglycerides	X	
20. Kidney disease or condition		X
21. Peripheral vascular disease or peripheral arterial disease		X
22. Phlebitis		X
23. Pulmonary embolism/blood clot to the lungs		X
24. Pulmonary hypertension		X
25. Raynaud's syndrome		X
26. Stroke or transient ischemic attack/TIA		X
27. Vasculitis		X

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Name of Family Member	Condition	Age When Condition Discovered	Cause of Death (if Applicable)
Shirley Griffin	High blood pressure	50	Cardiac arrest
Shirley Griffin	High cholesterol	50	Cardiac arrest
Shirley Griffin	Diabetes	50	Cardiac arrest
Shirley Griffin	Ulcers	56	Cardiac arrest

V. BEXTRA® PRESCRIPTION INFORMATION

A. Prescriber and Pharmacy Information:

1. Who prescribed BEXTRA® for you? Dr. Nirmala Amaram
2. Prescriber's address: 302 Uvalda Street, Waycross, GA
3. Name of pharmacy where prescription filled: The Medicine Shoppe
4. Address of pharmacy: 979 Tebeau Street, Waycross, GA 31501

B. Identify the following for each period of time during which you took BEXTRA®:

Dosage (10 mg or 20 mg)	How often per day?	Date Started	Date Stopped	Condition for which Prescribed
20mg	1	June 2004	November 2004	Pain

C. Did you receive any samples of BEXTRA®?

Yes ___ **No** X If **Yes**, please state the following:

1. Who provided the samples? _____
2. When were samples provided? _____
3. What was the dosage of the samples? _____
4. How many samples were provided? _____

D. Instructions or Warnings: Did you receive any written and/or oral information, including but not limited to instructions or warnings, about BEXTRA® at any time?

Yes __ **No** _X_ I don't recall _____ If **Yes**, please state the following:

Information Received	Written or Oral	When Received	From Whom Received

VI. MEDICAL BACKGROUND

A. Height: __5'7"_____

B. Current Weight: 190 lbs____

C. Weight at the time of the injury described in Section II: 190 lbs____

D. Tobacco Use History: Check the answer and fill in the blanks applicable to your history of tobacco use. Tobacco use includes smoking cigarettes, cigars, pipes and/or using chewing tobacco/snuff.

_____ I have never used tobacco.

X_____ I used tobacco in the past.

_____ Date tobacco use started: _____ Date tobacco use ceased: _____

Amount used: on average _____ per day for _____ years.

_____ I currently use tobacco.

Date tobacco use started: _____

Amount currently using: on average _____ per day for _____ years.

_____ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates and frequency of use below).

_____

_____

E. Alcohol Consumption: Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes _____ **No** __X_____ If **Yes**, fill in the appropriate blank with the number of drinks that best represents your average alcohol consumption during the last 10 years:

_____ drinks per week; _____ drinks per month; _____ drinks per year; or

Other (describe): _____

_____

What types of alcohol have you mostly consumed?

_____

F. Illicit Drugs: Have you used (even one time) any illicit drugs of any kind?

Yes ___ **No** X_ If **Yes**, identify each substance and when you first and last used it:

_____

G. Allergic Reactions: If you are claiming you suffered any type of skin reaction as a result of taking BEXTRA®, please indicate whether you have ever experienced an allergic reaction to medicine.

Yes ___ **No** X_ **Not Applicable** ____ If **Yes**, please state the following:

Name of Medication	When Allergy Diagnosed	Symptoms of Allergy	Doctor Who Diagnosed Allergy

H. Have **you** ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please provide the additional information requested in the table following this chart:

Condition You Experienced or That Was Diagnosed	Yes	No
1. Abnormal heart rhythm, atrial fibrillation, or heart block		X
2. Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		X
3. Arteriosclerosis/hardening of the arteries/stenosis		X
4. Arthritis (osteoarthritis or rheumatoid arthritis) **I do not recall**		
5. Atherosclerosis/blocked or narrow arteries/coronary artery disease		X
6. Autoimmune diseases (e.g., lupus, Sjögren's, etc.)		X
7. Bleeding or clotting disorders		X
8. Cancer (e.g., colon, lung, breast, skin, other)		X
9. Cardiomyopathy/enlarged heart		X
10. Chest pain/angina		X
11. Chronic obstructive pulmonary disease/COPD/chronic lung disease		X
12. Congenital heart abnormality or condition		X
13. Congestive heart failure		X
14. Deep vein thrombosis/DVT		X
15. Dermatologic diseases or conditions		X

16. Diabetes	X	
17. Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD)	X	
18. Heart attack/MI/myocardial infarction	X	
19. Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)	X	
20. High blood pressure/hypertension	X	
21. High cholesterol or triglycerides	X	
22. Immune system disease or dysfunction (including HIV or AIDS)		X
23. Kidney disease or condition		X
24. Liver disorder or disease (cirrhosis, hepatitis, etc.)		X
25. Peripheral vascular disease or peripheral arterial disease		X
26. Phlebitis		X
27. Pulmonary embolism/blood clot to the lungs		X
28. Pulmonary hypertension		X
29. Raynaud's syndrome		X
30. Rheumatic Fever		X
31. Scarlet Fever		X
32. Stroke or transient ischemic attack/TIA		X
33. Thyroid condition	X	
34. Vasculitis		X

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below (attach additional sheets as needed):

Condition You Experienced	Date of Onset	Medication/ Treatment	Treating Physician	Current Status of Condition
Thyroid	1970	Do not recall	Dr.Nirmala Armaram	deceased
Stroke	2004	Do not recall	Dr. Jay Patterson	deceased
Ulcers	2004	Do not recall	Dr.Nirmala Armaram	deceased
Heart valve	2004	Do not recall	Dr. Jay Patterson	deceased
High blood pressure	1989	Do not recall	Dr.Nirmala Armaram	deceased
High cholesterol	1989	Do not recall	Dr.Nirmala Armaram	deceased

I. Please indicate whether you have ever received any of the following treatments or procedures and provide the requested information about each.

1. **Cardiovascular Surgeries.** This includes but is not limited to open heart/bypass surgery, pacemaker implantation, stent placement, vascular surgery, IVC filter placement, carotid (neck artery) surgery, or valve replacement.

Yes __X__ **No** _____ I don't recall ____ If **Yes**, please specify the following:

Surgery	Condition	Date	Treating Physician	Hospital
Stent implant	Blood Clot	November 2004	Dr. Jay Patterson	St. Vincent's Medical Center

2. Treatment for heart attack, angina (chest pain), or lung ailments (other than as described in your response to question 1 above):

Yes ____ **No** __X__ I don't recall _____ If **Yes**, please specify the following:

Treatment	Date	Treating Physician	Hospital

3. **Cardiovascular Diagnostic Tests.** This includes but is not limited to C-reactive protein (CRP), chest X-ray, angiogram/catheterization, CT scan, MRI, EKG, echocardiogram, TEE (trans-esophageal echo), endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head/neck, CT scan of the head, bubble/microbubble study, and Holter monitor.

Yes __X__ **No** _____ I don't recall _____ If **Yes**, please specify the following:

Diagnostic Test	Reason for Test	Date	Treating Physician/ Hospital	Result of Diagnostic Test
Catherization	Heart	Nov 2004	Dr. Willie Bell	Sent to Jacksonville for stent implant

VII. ADDITONAL MEDICATIONS

A. Please indicate whether you have taken any of the following medications in the past ten (10) years. If you answer **Yes** for any medication, please indicate whether you recall ever taking that medication on a daily basis for more than two months at a time.

Name of Medication	Yes	No	Don't Recall	Do You Recall Daily Use for More Than Two Months?
Advil®/Motrin®/Ibuprofen	X			No
Aleve®/Naprosyn/Naproxen			X	
Aspirin (Bayer®, Bufferin®, Ascriptin®, Ecotrin®)			X	
Celebrex®, Celecoxib			X	
Codeine			X	
Darvocet/Darvocet-N			X	
Demerol			X	
Mobic®/Meloxicam			X	
Morphine			X	
OxyContin			X	
Percocet	X			No
Tylenol®/Acetaminophen			X	
Ultram®/Tramadol			X	
Vioxx®/Rofecoxib			X	
Voltaren®/Cataflam/Diclofenac			X	

B. Have you ever experienced any gastrointestinal side effects (for example, nausea, stomach pain, vomiting, diarrhea, constipation, ulcers, heartburn, reflux, or esophageal reflux disease/GERD) or any other side effects while you were taking any of the medications identified in your answer to question A above?

Yes _X_ **No** __ If **Yes**, please state the following:

Name of Medication	Side Effects	Date(s) Experienced
Nexium	None	1998-2004

VIII. MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

A. Identify each doctor or other healthcare provider who has provided treatment to you in the past ten (10) years (attach additional sheets as needed).

Name	Address	Approximate Dates
Dr. Nirmala Armaram	302 Uvalda Street, Waycross GA	Do not recall
Dr. Jay Patterson	1824 King Street, Suite 300, Jacksonville, Florida 32204	Do not recall
Dr. Willie Bell	1108 Bimni Road, Jacksonville, Florida 32216	Do not recall
Dr. William Dial	501 Oneida Street, Waycross, GA 31501	Do not recall

B. Identify each hospital, clinic, or healthcare facility where you have received inpatient or outpatient treatment or been admitted as a patient during the last ten (10) years (attach additional sheets as needed).

Name	Address	Admission Date(s)	Reason for Admission
Satilla Regional Medical Center	410 Darling Avenue, Waycross GA 31501	2004	Blood, vomiting
St. Vincent's Medical Center	1800 Barrs Street, Jacksonville, Florida 32204	2004	Heart

C. Identify each pharmacy that has dispensed medication to you in the last ten (10) years (attach additional sheets as needed).

Name of Pharmacy	Address of Pharmacy
The Medicine Shoppe	979 Tebeau Street, Waycross GA 31501

D. If you have submitted a claim for social security disability or workers' compensation benefits in the last ten (10) years, what agency or entity is most likely to have records concerning your claim (attach additional sheets as needed)?

Name	Address
Social Security Office	303 Isabella Street, Waycross GA 31501

IX. DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, control, or in the possession, custody, or control of your lawyers, by checking **Yes** or **No**. Where you have indicated **Yes**, please attach the documents and materials to your responses to this Fact Sheet.

A. Records and bills of physicians, hospitals, pharmacies, other healthcare providers, government agencies, insurance companies, or any other entities identified in response to this Fact Sheet. **Yes** ____ **No** X

B. Decedent's death certificate (if applicable). **Yes** X **No** ___

C. Report of autopsy of decedent (if applicable). **Yes** _____ **No** X

D. Any copies of the packaging, include the bottle, box, and label for BEXTRA® and any unused medication. **Yes** X **No** _

E. Prescriptions or receipts for BEXTRA®. **Yes** X ____ **No** __

F. If you are claiming lost wages or a loss of earning capacity, your W-2 forms for each of the last five (5) years. **Yes** __ **No** X

CERTIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Plaintiff Fact Sheet is true, complete and correct to the best of my knowledge, that I have supplied all the documents requested in part IX. Of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and htat I have supplied the authorizations attached to this declaration. Further, I acknowledge that I must supplement my responses if I learn that they are incomplete or incorrect in any material respect.

Signature: William M Griffin

Print Name: WILLIAM M GRIFFIN

Date: 4/22/08

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

IN RE BEXTRA AND CELEBREX MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	Master Docket No. M:05-CV-01699-CRB MDL No. 1699
THIS RELATES TO: MDL Case No. _____	Plaintiff: _____ (name)

Name: _____

Date of Birth: _____

Social Security Number: _____

AUTHORIZATION FOR RELEASE OF RECORDS FROM EMPLOYER

(No Wage Loss Claimed)

This authorization does NOT authorize the release of records regarding the Employee's pay, salary, income or other financial compensation, including, but not limited to, paychecks, paystubs and tax documents including W-4 and W-2 forms, or records of reproductive treatment (except for records of birth control medications). DO NOT RELEASE such records.

Person/Entity from Whom Records are Requested ("Provider"):

_____
Name of Employer/Educational Institution

_____
Address City, State and Zip Code

Employee:

_____
Employee Name ("Employee")

_____
Address City, State and Zip Code

Information Authorized To Be Disclosed: I authorize the Provider to furnish all records in its possession including but not limited to: the Employee's employment and education, copies of all applications for employment, resumes, records of all positions held, job descriptions of positions held, performance evaluations and reports, statements and comments of fellow employees, attendance records, all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physician examination records, any records pertaining to claims made relating to health, disability or accidents in which the employee was involved including correspondence, reports, claim forms, questionnaires, medical reports, workers' compensation claims, and all other records relating to employment, past and present, and claims for disability. This listing is not meant to be exclusive.

This authorization does NOT authorize the release of records regarding the Employee's pay, salary, income or other financial compensation, including, but not limited to, paychecks, paystubs and tax documents including W-4 and W-2 forms, or records of reproductive treatment (except for records of birth control medications). DO NOT RELEASE such records.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Marketing, Sales Practices and Products Liability Litigation*, Master Docket No. M:05-CV-01699-CRB, MDL No. 1699, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants - Attn: RECORD RETRIEVAL
Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.
Relationship to Recipient

6330 West Loop South, Suite 105 Bellaire, TX 77401
Address City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: I understand that I may revoke this authorization at any time by writing to the Employer at the Employer's above address, but my revocation will not apply to information that has already been released before the Employer receives notice of any revocation. Cancellation, revocation, or modification will only be valid once the Employer receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Stuart M. Gordon at Gordon & Rees. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____ William R Griffin

Signature of Employee or Legal/Personal Representative

_____

Description of Personal Representative's Authority to Sign for Employee

FOR MRC USE ONLY –

Plaintiff's Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer's Name(s): _____

Firm Name: _____

Lawyer's Email(s): _____

(Required) _____

_____

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U. S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parents' names)
____ Monthly Social Security benefit amount
____ Monthly Supplemental Security Income payment amount
____ Information about benefits/payments I received from _____ to _____
____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
____ Medical records
____ Record(s) from my file (specify) _____
____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: William M Griffin

(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

IN RE BEXTRA AND CELEBREX MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	Master Docket No. M:05-CV-01699-CRB MDL No. 1699
THIS RELATES TO: MDL Case No. _____	Plaintiff: _____ (name)

Name: _____

Date of Birth: _____

Social Security Number: _____

HIPAA COMPLIANT AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

(Psychological Injury Claimed)

This authorization does NOT authorize the release of records of reproductive treatment (except for records of birth control medications). DO NOT RELEASE such records.

Person/Entity from Whom Records are Requested:

_____
Provider Name ("Provider")

_____
Address City, State and Zip Code

Patient:

_____
Patient Name

_____
Address City, State and Zip Code

Information Authorized To Be Disclosed: I authorize the Provider to furnish copies of my entire medical record and all of my individually identifiable health information, to include but not be limited to: x-ray reports, CT scan reports, echocardiographic recordings, radiographic films, blood tests, MRI scans, MRA films, EEGs, EKGs, sonograms, arteriogram, pathology specimens, discharge summaries, photographs, videos, DVDs, emails, or other electronically stored information, data, or images, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes, progress notes, prescriptions, medical bills, medical reports and records, invoices, histories, diagnoses, narratives, correspondence, memoranda, and billing information, pharmacy/prescription records including NDC numbers and drug information handouts/monographs. If the Provider is in possession of records from any other source, I authorize release of those records under this authorization.

This authorization includes records for treatment of psychological, psychiatric and emotional problems. It also includes, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

This authorization does NOT authorize the release of records of reproductive treatment (except for records of birth control medications). DO NOT RELEASE such records.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Marketing, Sales Practices and Products Liability Litigation*, Master Docket No. M:05-CV-01699-CRB, MDL No. 1699, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants – Attn: RECORD RETRIEVAL
Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.
Relationship to Recipient

6330 West Loop South, Suite 105 Bellaire, TX 77401
Address City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for (please initial):

_____ Drug or alcohol abuse

_____ Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other sexually transmitted diseases

_____ Sickle Cell Anemia

_____ Tuberculosis

_____ Genetic testing and counseling

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: I understand that I may revoke this authorization at any time by writing to the Provider at the Provider's above address, but my revocation will not apply to information that has already been released before the Provider receives notice of any revocation. Cancellation, revocation, or modification will only be valid once the Provider receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Stuart M. Gordon at Gordon & Rees. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____ William M. Griffin

Signature of Patient or Legal/Personal Representative

_____

Description of Representative's Authority to Act for Patient, if Applicable

FOR MRC USE ONLY –

Plaintiff's Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer's Name(s): _____

Firm Name: _____

Lawyer's Email(s): _____

(Required) _____

_____

Form Approved
OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**

   Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. **Certified Yearly Totals of Earnings**

   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Earnings and Benefit Estimate Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

- **How Do I Get This Information?**

  You need to complete the attached form to tell us what information you want.

- **Can I Get This Information For Someone Else?**

  Yes, if you have their written permission. For more information, see page 3.

- **Who Can Sign On Behalf Of The Individual?**

  The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

- **Is There A Fee For This Information?**

  1. **Certified/Non-Certified Detailed Earnings Information**

     Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

     Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

     Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

     We will certify the detailed earnings information for an additional fee of $15.00. Certification is usually not necessary unless you plan to use the information in court.

  2. **Certified Yearly Total of Earnings**

     Yes, there is a fee of $15 to certify yearly totals of earnings. Cetification is usually not necessary unless you plan to use the information in court.

  3. **Method of Payment**

     Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name _____ Social Security Number _____

   Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

   ☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

   _____

   _____

   ☐ **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

   Do you want us to certify the information? ☐ Yes ☐ No

   If yes, enter $15.00 . . . . . B. $ _____

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

   SIGN your name here (Do not print) > William M Griffin Date _____

   Daytime Phone Number _____ _____
   (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name _____ Address _____

   City, State & Zip Code _____

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	$15.00	15	$43.75	28	$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

- **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order.

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception:
If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

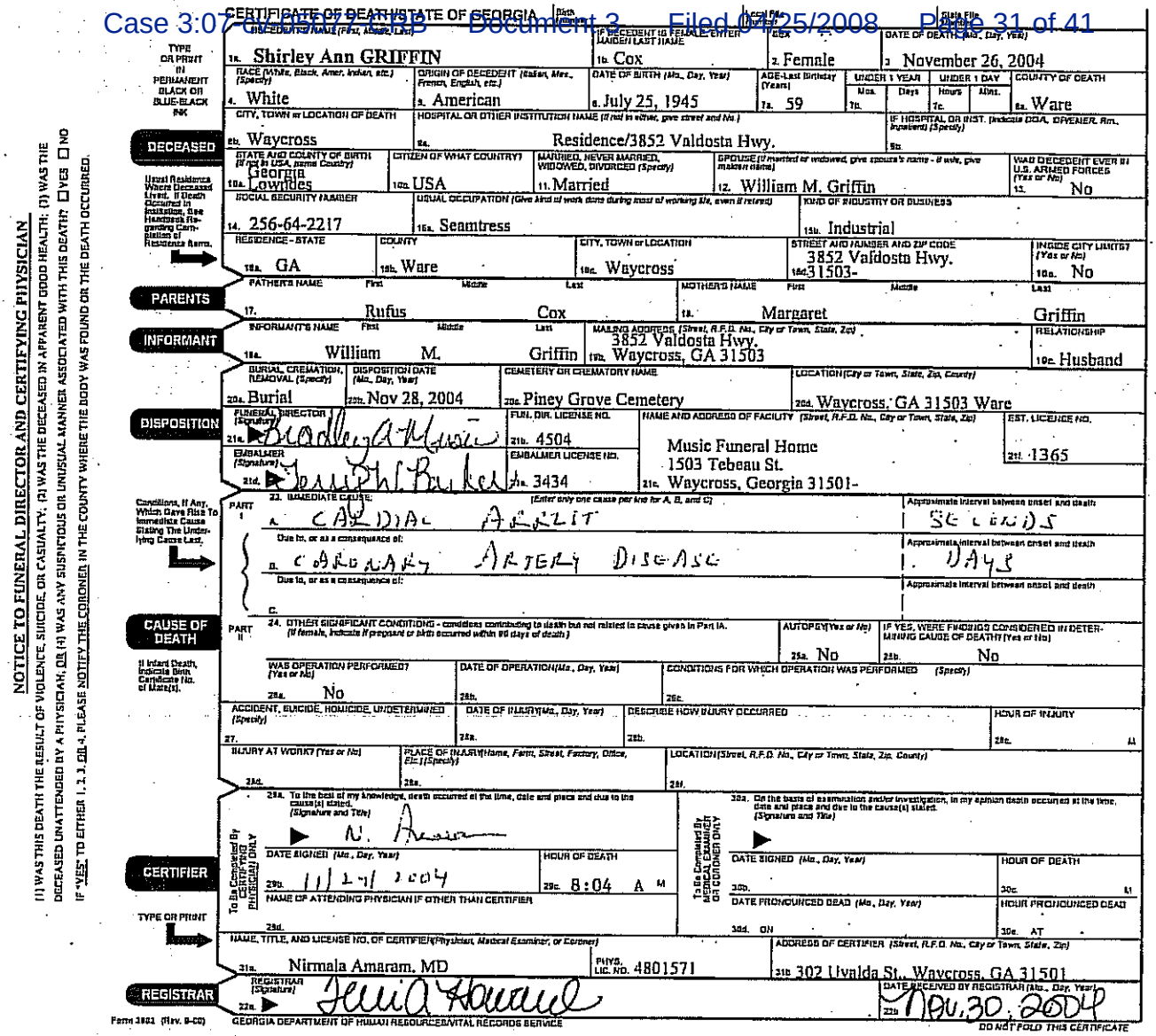
CHECK ONE →	☐ Visa ☐ American ☐ MasterCard ☐ Discover ☐ Diners Card
Credit Card Holder's Name → (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address →	Number & Street City, State, & Zip Code
Daytime Telephone Number →	Area Code Telephone Number
Credit Card Number →	-- -- --
Credit Card Expiration Date →	Month Year
Amount Charged →	
Credit Card Holder's Signature →	

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.



CERTIFICATE OF DEATH STATE OF GEORGIA

NOTICE TO FUNERAL DIRECTOR AND CERTIFYING PHYSICIAN
(1) WAS THIS DEATH THE RESULT OF VIOLENCE, SUICIDE, OR CASUALTY; (2) WAS THE DECEASED IN APPARENT GOOD HEALTH; (3) WAS THE DECEASED UNATTENDED BY A PHYSICIAN; OR (4) WAS ANY SUSPICIOUS OR UNUSUAL MANNER ASSOCIATED WITH THIS DEATH? ☐ YES ☐ NO
IF "YES" TO EITHER 1, 2, 3, OR 4, PLEASE NOTIFY THE CORONER IN THE COUNTY WHERE THE BODY WAS FOUND OR THE DEATH OCCURRED.

DECEASED
1a. Shirley Ann GRIFFIN
1b. Cox
2. Female
3. November 26, 2004
4. White
5. American
6. July 25, 1945
7a. 59
8a. Ware
8b. Waycross
8c. Residence/3852 Valdosta Hwy.
10a. Georgia
10b. USA
11. Married
12. William M. Griffin
13. No
14. 256-64-2217
15a. Seamtress
15b. Industrial
16a. GA
16b. Ware
16c. Waycross
16d. 3852 Valdosta Hwy. 31503-
16e. No

PARENTS
17. Rufus Cox
18. Margaret Griffin

INFORMANT
19a. William M. Griffin
19b. 3852 Valdosta Hwy. Waycross, GA 31503
19c. Husband

DISPOSITION
20a. Burial
20b. Nov 28, 2004
20c. Piney Grove Cemetery
20d. Waycross, GA 31503 Ware
21a. Bradley A Music
21b. 4504
21c. Music Funeral Home
1503 Tebeau St.
Waycross, Georgia 31501-
21d. 1365
21e. Jennifer Barker
21f. 3434

CAUSE OF DEATH
PART I
22. IMMEDIATE CAUSE: (Enter only one cause per line for A, B, and C)
a. CARDIAC ARREST — Approximate interval between onset and death: SECONDS
Due to, or as a consequence of:
b. CORONARY ARTERY DISEASE — Approximate interval between onset and death: DAYS
Due to, or as a consequence of:
c.
PART II
23. OTHER SIGNIFICANT CONDITIONS - conditions contributing to death but not related to cause given in Part Ia.
24a. AUTOPSY (Yes or No): No
24b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? (Yes or No): No
25a. WAS OPERATION PERFORMED? (Yes or No): No
25b. DATE OF OPERATION (Mo., Day, Year)
25c. CONDITIONS FOR WHICH OPERATION WAS PERFORMED (Specify)
26. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify)
27a. DATE OF INJURY (Mo., Day, Year)
27b. DESCRIBE HOW INJURY OCCURRED
27c. HOUR OF INJURY
28a. INJURY AT WORK? (Yes or No)
28b. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify)
28c. LOCATION (Street, R.F.D. No., City or Town, State, Zip, County)

CERTIFIER
29a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)
N. Amaram
29b. DATE SIGNED (Mo., Day, Year): 11/24/2004
29c. HOUR OF DEATH: 8:04 A M
29d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER
30a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)
30b. DATE SIGNED (Mo., Day, Year)
30c. HOUR OF DEATH
30d. DATE PRONOUNCED DEAD (Mo., Day, Year)
30e. HOUR PRONOUNCED DEAD

REGISTRAR
31a. NAME, TITLE, AND LICENSE NO. OF CERTIFIER (Physician, Medical Examiner, or Coroner): Nirmala Amaram, MD
PHYS. LIC. NO. 4801571
31b. ADDRESS OF CERTIFIER (Street, R.F.D. No., City or Town, State, Zip): 302 Uvalda St., Waycross, GA 31501
32a. REGISTRAR (Signature): Terri A Howard
32b. DATE RECEIVED BY REGISTRAR (Mo., Day, Year): Nov. 30, 2004

Form 3911 (Rev. 9-00) GEORGIA DEPARTMENT OF HUMAN RESOURCES/VITAL RECORDS SERVICE — DO NOT FOLD THIS CERTIFICATE

STATE OF GEORGIA

"CERTIFICATE OF RECORD"

"THIS IS AN EXACT COPY OF THE DEATH CERTIFICATE RECEIVED FOR FILING IN WARE COUNTY, GEORGIA.

Terri A. Howard
Terri A. Howard
Local Custodain of Vital Records

BY: Terri A Howard
Local Custodain Office

WARE COUNTY

DATE: Nov. 30, 2004

(Void without original signature and impressed seal)

SEAL

The Medicine Shoppe
979 Tebeau Street

Waycross, GA 31501

Fed ID# 58 2359797
NABP# 1131262
Phone# 912 285 7631

We are pleased to provide this service to our valued customer.

GRIFFIN, SHIRLEY
3852 VALDOSTA HIWAY

WAYCROSS, GA 31501

Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
255451	3	06/09/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
255451	4	07/22/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
255451	5	09/24/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
255451	6	10/29/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
255516		02/26/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255516	1	03/26/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255516	2	05/02/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255516	3	06/09/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255516	4	07/22/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255516	5	08/29/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255516	6	09/29/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
255517		02/26/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	3.01
255517	1	03/26/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	3.01
255517	2	04/14/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	3.01
255517	3	05/14/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	3.01
255517	4	07/01/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	3.01
255518		02/26/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
255518	1	04/04/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
255518	2	05/12/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
255518	3	06/16/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
255518	4	07/11/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
255518	5	08/15/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
255518	6	09/22/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
256168		03/06/03	DYE, JAMES WADE	15	MACROBID 100MG CAP NORWICH	00149071001	INS.	5.87
256168	1	03/19/03	DYE, JAMES WADE	15	MACROBID 100MG CAP NORWICH	00149071001	CASH	35.50
256168	2	04/14/03	DYE, JAMES WADE	15	MACROBID 100MG CAP NORWICH	00149071001	INS.	5.92
256613		03/12/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
256614		03/12/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
256798		03/17/03	AMARAM, CHANDRAK	3	CIPRO XR 500MG TAB	00026888950	INS.	5.02
258492		04/14/03	AMARAM, CHANDRAK	60	MEPERIDINE & PROMETH 50/25 C	00603442421	INS.	5.00
258493		04/14/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
258494		04/14/03	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
258494	1	06/09/03	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
258495		04/14/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	1	06/09/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	2	07/01/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	3	07/22/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	4	08/19/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	5	09/16/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	6	10/20/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258495	7	11/20/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
258752		04/17/03	AMARAM, CHANDRAK	60	ADVAIR DISKUS 250/50 60	00173069600	INS.	15.00
258824		04/18/03	AMARAM, CHANDRAK	5	AVELOX 400MGM TAB	00026858169	INS.	9.03
259020		04/22/03	AMARAM, CHANDRAK	10	CIPRO 250MG TABS MILES	00026851251	INS.	8.87
259689		05/02/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
259689	1	06/03/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
259689	2	07/01/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
260468		05/14/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
260471		05/14/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
261612		06/03/03	AMARAM, CHANDRAK	30	FUROSEMIDE 40MG TAB GENEVA	00781196610	INS.	.89

The Medicine Shoppe
979 Tebeau Street

Waycross, GA 31501

Fed ID# 58 2359797
NABP# 1131262
Phone# 912 285 7631

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GRIFFIN, SHIRLEY
3852 VALDOSTA HIWAY

WAYCROSS, GA 31501

Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
261612	1	08/13/03	AMARAM, CHANDRAK	30	FUROSEMIDE 40MG TAB GENEVA	00781196610	INS.	.89
261612	2	10/29/03	AMARAM, CHANDRAK	30	FUROSEMIDE 40MG TAB GENEVA	00781196610	INS.	.89
261612	3	04/21/04	AMARAM, CHANDRAK	30	FUROSEMIDE 40MG TAB GENEVA	00781196610	INS.	.79
262144		06/11/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
262145		06/11/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
263365		07/01/03	AMARAM, CHANDRAK	120	METFORMIN HCL 500MG TAB	00172433160	INS.	5.00
263365	1	07/29/03	AMARAM, CHANDRAK	120	METFORMIN HCL 500MG TAB	00172433160	INS.	5.00
263365	2	09/08/03	AMARAM, CHANDRAK	120	METFORMIN HCL 500MG TAB	00172433160	INS.	5.00
263366		07/01/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
263366	1	08/15/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
263366	2	09/16/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	5.13
263367		07/01/03	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
263367	1	07/22/03	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
263367	2	08/15/03	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
263367	3	09/08/03	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
263799		07/08/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
263800		07/08/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
264026		07/11/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
264026	1	08/15/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
264026	2	09/22/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
264026	3	10/27/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
264026	4	12/03/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
264550		07/21/03	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.83
264834		07/24/03	AMARAN, NIRMALA	1	ELOCON 0.1% CREAM 45GM SCHER	00085056702	INS.	8.82
265335		08/01/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
265335	1	09/08/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
265335	2	09/24/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
265335	3	10/29/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
265335	4	12/03/03	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.40
265335	5	01/13/04	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.55
265335	6	03/23/04	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.55
265335	7	06/18/04	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.55
265336		08/01/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
265336	1	09/05/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
265336	2	10/10/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
265336	3	11/13/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
265336	4	12/16/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
265336	5	01/28/04	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00074706813	INS.	3.39
265336	6	03/12/04	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00074706813	INS.	3.39
265336	7	04/21/04	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00074706813	INS.	3.54
265336	8	06/10/04	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00074706813	INS.	3.54
265337		08/01/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	3.01
265337	1	08/27/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	3.01
265337	2	10/29/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	3.01
265337	3	12/16/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	3.01
265337	4	02/09/04	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	2.97
265519		08/05/03	AMARAM, CHANDRAK	6	ZITHROMAX 250MG TAB	00069306030	INS.	8.69
265684		08/07/03	AMARAN, NIRMALA	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
265685		08/07/03	AMARAN, NIRMALA	60	MEPROZINE	00603442421	INS.	5.00
266216		08/26/03	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00

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Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
266216	1	09/16/03	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
266216	2	10/14/03	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
266216	3	11/13/03	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
266784		08/26/03	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.83
266784	1	10/06/03	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.83
266784	2	11/13/03	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.83
267491		09/08/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
267492		09/08/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
267509		09/08/03	MORTON, DAVID K.	30	AMOXICILLIN 500MG CAP	55370088508	INS.	1.39
268361		09/22/03	MARAMREDDY, P	5	LEVAQUIN 500MG TABS	00045152550	INS.	9.70
268444		09/22/03	IRFAN, AHMAD	12	HEMORRHOIDAL HC SUPP 12'S	00603812711	INS.	1.78
268444	1	07/30/04	IRFAN, AHMAD	12	HEMORRHOIDAL HC SUPP 12'S	00603812711	INS.	1.64
268903		09/30/03	AMARAM, CHANDRAK	10	ZYRTEC 10MG TAB PFIZER	00069551066	INS.	4.17
268904		09/30/03	AMARAM, CHANDRAK	5	AVELOX 400MG TAB	00026858169	INS.	9.03
269581		10/10/03	AMARAM, CHANDRAK	1	HUMULIN 70/30 INSULIN LILLY	00002871501	INS.	5.13
269581	1	10/29/03	AMARAM, CHANDRAK	1	HUMULIN 70/30 INSULIN LILLY	00002871501	INS.	5.13
269582		10/10/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
269583		10/10/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
270577		10/27/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
270577	1	12/03/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
270577	2	01/09/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
270577	3	02/12/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
270715		10/29/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	1	12/03/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	2	01/15/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	3	02/18/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	4	03/26/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	5	04/21/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	6	05/27/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	7	06/24/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	8	07/30/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270715	9	09/21/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
270717		10/29/03	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.42
270717	1	03/26/04	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.41
271138		11/04/03	MORTON, DAVID K.	12	PROPOXYPHENE APAP/100/650	00378015505	INS.	1.00
271557		11/10/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
271558		11/10/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
271870		11/14/03	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.15
271870	1	12/03/03	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.15
271870	2	12/19/03	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.15
271870	3	01/19/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	11.77
271870	4	02/06/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	11.77
271870	5	02/27/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	11.77
271870	6	03/17/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	11.77
272754		11/28/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
272754	1	12/29/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
272754	2	01/27/04	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
272754	3	02/27/04	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
272754	4	05/03/04	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
272754	5	06/10/04	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00

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Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
272754	6	07/16/04	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
272754	7	09/21/04	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
273442		12/24/03	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
273442	1	02/12/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
273554		12/10/03	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273554	1	01/15/04	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273554	2	02/12/04	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273554	3	03/26/04	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273554	4	04/21/04	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273554	5	06/10/04	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273554	6	07/07/04	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
273555		12/10/03	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.93
273555	1	01/27/04	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.76
273555	2	02/27/04	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.76
273555	3	03/31/04	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.76
273555	4	06/02/04	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.76
273555	5	07/30/04	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.76
273555	6	09/21/04	AMARAM, CHANDRAK	60	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.76
273556		12/10/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
273557		12/10/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
273829		12/15/03	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.83
273829	1	01/27/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67
274201		12/19/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	1	01/19/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	2	02/18/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	3	03/17/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	4	04/21/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	5	06/10/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	6	07/16/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	7	08/23/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
274201	8	09/21/04	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
275473		01/09/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
275474		01/09/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
276739		01/30/04	AMARAM, CHANDRAK	1	CLOTRIM/BETAMETH DIPRO CR.45	00168025846	INS.	5.00
276739	1	07/30/04	AMARAM, CHANDRAK	1	CLOTRIM/BETAMETH DIPRO CR.45	00168025846	INS.	5.00
277365		02/09/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
277366		02/09/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
277758		03/17/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
277758	1	05/03/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
277758	2	07/07/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
277758	3	08/23/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
277758	4	09/21/04	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
279236		03/08/04	IRFAN, AHMAD	24	HEMORRHOIDAL HC SUPP 12'S	00603812711	INS.	2.89
279236	1	05/06/04	IRFAN, AHMAD	24	HEMORRHOIDAL HC SUPP 12'S	00603812711	INS.	2.89
279236	2	06/21/04	IRFAN, AHMAD	24	HEMORRHOIDAL HC SUPP 12'S	00603812711	INS.	2.89
279236	3	09/21/04	IRFAN, AHMAD	24	HEMORRHOIDAL HC SUPP 12'S	00603812711	INS.	2.89
279237		03/08/04	IRFAN, AHMAD	60	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	5.00
279237	1	07/07/04	IRFAN, AHMAD	60	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	5.00
279237	2	09/21/04	IRFAN, AHMAD	60	PROMETHAZINE 25MG TAB WATSON	00591530701	INS.	5.00
279238		03/08/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67

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Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
232349	9	01/28/03	AMARAM, CHANDRAK	30	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	3.01
232351	8	01/28/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
235175	7	01/28/03	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
240126	8	01/14/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
240126	9	02/06/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
240126	10	02/21/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
240126	11	03/17/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
240126	12	04/04/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
240126	13	05/12/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
240126	14	06/09/03	AMARAM, CHANDRAK	1	HUMULIN N INSULIN LILLY HI 3	00002831501	INS.	4.69
242343	3	01/14/03	AMARAM, CHANDRAK	1	HUMALOG INSULIN INJECTION 10	00002751001	INS.	11.19
242343	4	02/21/03	AMARAM, CHANDRAK	1	HUMALOG INSULIN INJECTION 10	00002751001	INS.	11.19
242343	5	04/04/03	AMARAM, CHANDRAK	1	HUMALOG INSULIN INJECTION 10	00002751001	INS.	11.19
242343	6	05/30/03	AMARAM, CHANDRAK	1	HUMALOG INSULIN INJECTION 10	00002751001	INS.	11.19
242343	7	07/29/03	AMARAM, CHANDRAK	1	HUMALOG INSULIN INJECTION 10	00002751001	INS.	11.19
244706	4	01/28/03	AMARAM, CHANDRAK	60	LOTREL 5/20 CAP	00083226530	INS.	15.00
244804	4	01/02/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
244804	5	01/28/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
244804	6	02/26/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
244804	7	03/26/03	AMARAM, CHANDRAK	30	NEXIUM 40MG CAP	00186504031	INS.	15.00
244805	5	01/28/03	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
244805	6	02/26/03	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
244805	7	03/26/03	AMARAM, CHANDRAK	30	CELEBREX 200MG CAP	00025152531	INS.	15.00
246732	2	04/14/03	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.50
246732	3	08/13/03	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.10
247124	3	01/28/03	AMARAM, CHANDRAK	30	METFORMIN HCL 500MG TAB	00172433160	INS.	2.92
249306	2	01/28/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	2.55
249306	3	02/26/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
249306	4	04/04/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
249306	5	05/12/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
249306	6	06/16/03	AMARAM, CHANDRAK	30	ATENOLOL 50MG TAB MYLAN	00378023110	INS.	1.21
252379		01/13/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
252380		01/13/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
252748		01/17/03	AMARAM, CHANDRAK	10	AVELOX 400MG TAB	00026858169	INS.	15.00
252749		01/17/03	AMARAM, CHANDRAK	6	PROMETHAZINE 25MG TAB WATSON	00781183010	INS.	1.00
254117		02/06/03	AMARAM, CHANDRAK	20	AMOX/CLAVUL 875/125 TAB	00093227534	INS.	5.00
254118		02/06/03	AMARAM, CHANDRAK	10	DIPHENOXYLATE/ATROPINE TAB	65162030110	INS.	1.03
254547		02/12/03	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
254548		02/12/03	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	4.84
255171		02/21/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
255171	1	03/26/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
255171	2	04/17/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
255171	3	05/27/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
255171	4	07/01/03	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00048113003	INS.	3.07
255450		02/25/03	AMARAM, CHANDRAK	60	METFORMIN HCL 500MG TAB	00172433160	INS.	5.00
255450	1	03/26/03	AMARAM, CHANDRAK	60	METFORMIN HCL 500MG TAB	00172433160	INS.	5.00
255450	2	04/25/03	AMARAM, CHANDRAK	60	METFORMIN HCL 500MG TAB	00172433160	INS.	5.00
255451		02/25/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
255451	1	03/26/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00
255451	2	04/25/03	AMARAM, CHANDRAK	30	LIPITOR 40MG TAB	00071015723	INS.	15.00

The Medicine Shoppe
979 Tebeau Street

Waycross, GA 31501

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3852 VALDOSTA HIWAY

WAYCROSS, GA 31501

Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
279238	1	04/28/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67
279238	2	06/02/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67
279238	3	07/16/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67
279238	4	08/23/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67
279238	5	09/21/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	3.67
279238	6	11/23/04	IRFAN, AHMAD	120	METOCLOPRAMIDE 10MG SIDMAK	50111043002	INS.	13.69
279239		03/08/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
279239	1	04/21/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
279239	2	06/10/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
279239	3	07/16/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
279239	4	08/23/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
279239	5	09/21/04	IRFAN, AHMAD	60	ZELNORM 6MG TAB	00078035680	INS.	15.00
279322		03/09/04	AMARAN, NIRMALA	60	MEPROZINE	00603442421	INS.	5.00
279323		03/09/04	AMARAN, NIRMALA	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
279829		03/17/04	HARRINGTON, PAUL	100	SYRINGE U-100 LO-DOSE 1/2 CC	08290328466	INS.	4.76
279837		03/17/04	MURPHY, DAVID P.	30	PROPOXYPHENE APAP/100/650	00378015505	INS.	1.52
280499		05/06/04	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.41
280499	1	06/24/04	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.41
280499	2	08/23/04	AMARAM, CHANDRAK	30	POTASSIUM CL ER TAB 10MEQ	00781152610	INS.	1.41
280519		03/29/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	1	06/02/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	2	06/24/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	3	07/07/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	4	07/21/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	5	07/30/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	6	08/10/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	7	08/27/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	8	09/07/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	9	09/21/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	12.28
280519	10	10/05/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	3.31
280519	11	11/01/04	AMARAN, NIRMALA	1	HUMALOG MIX 75/25 10 ML	00002751101	INS.	3.31
280665		03/31/04	AMARAM, CHANDRAK	10	ZYRTEC 10MG TAB PFIZER	00069551066	INS.	4.13
280665	1	08/30/04	AMARAM, CHANDRAK	10	ZYRTEC 10MG TAB PFIZER	00069551066	INS.	4.13
280665	2	11/01/04	AMARAM, CHANDRAK	10	ZYRTEC 10MG TAB PFIZER	00069551066	INS.	1.30
281179		04/08/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
281180		04/08/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
282988		05/07/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
282989		05/07/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
283776		05/21/04	AMARAM, CHANDRAK	30	GLIPIZIDE 5MG ER TABS ANDRX	62037087201	INS.	2.47
283777		05/21/04	AMARAM, CHANDRAK	5	AVELOX 400MG TAB	00026858169	INS.	9.05
284339		06/02/04	AMARAM, CHANDRAK	30	FUROSEMIDE 40MG TAB GENEVA	00781196610	INS.	.79
284339	1	09/21/04	AMARAM, CHANDRAK	30	FUROSEMIDE 40MG TAB GENEVA	00781196610	INS.	.79
284655		06/07/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
284656		06/07/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
285112		06/15/04	AMARAM, CHANDRAK	8	AVELOX 400MG TAB	00026858169	INS.	14.25
286279		07/07/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
286280		07/07/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
287539		07/30/04	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00074706813	INS.	3.54
287539	1	09/21/04	AMARAM, CHANDRAK	30	SYNTHROID .125MG TAB FLINT	00074706813	INS.	3.54
287543		07/30/04	AMARAM, CHANDRAK	60	ADVAIR DISKUS 250/50 60	00173069600	INS.	15.00

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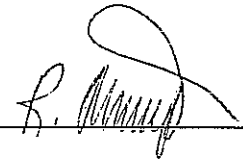
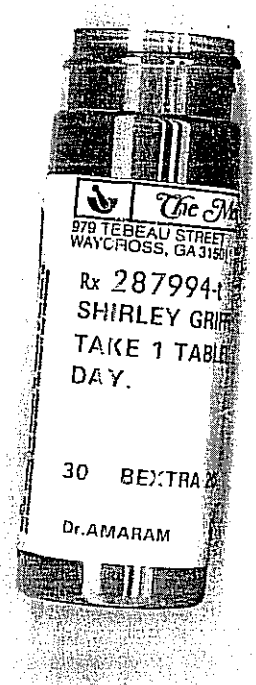
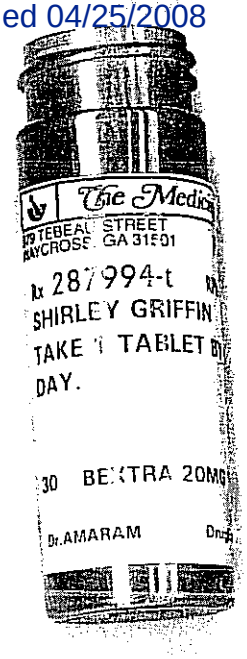
3852 VALDOSTA HIWAY

WAYCROSS, GA 31501

Rx#	Ref	Date	Doctor	Qty	Drug	NDC#	Type	CusPay
287543	1	09/21/04	AMARAM, CHANDRAK	60	ADVAIR DISKUS 250/50 60	00173069600	INS.	15.00
287992		08/06/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	5.00
287993		08/06/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
287994		08/06/04	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
287994	1	09/21/04	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
287994	2	11/23/04	AMARAM, CHANDRAK	30	BEXTRA 20MG TAB	00025198031	INS.	15.00
288342		08/13/04	AMARAM, CHANDRAK	30	GLIPIZIDE ER 10MG TAB ANDRX	62037087301	INS.	4.50
288342	1	09/21/04	AMARAM, CHANDRAK	30	GLIPIZIDE ER 10MG TAB ANDRX	62037087301	INS.	4.50
288775		08/23/04	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.55
288775	1	09/21/04	AMARAM, CHANDRAK	100	URISED TAB WEBCON	61451218301	INS.	10.55
289603		09/02/04	AMARAN, NIRMALA	60	MEPROZINE	00603442421	INS.	5.00
289604		09/02/04	AMARAN, NIRMALA	90	ALPRAZOLAM 1MG	59762372103	INS.	2.58
291193		10/01/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	CASH	22.75
291194		10/01/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	1.72
292809		10/28/04	IRFAN, AHMAD	30	NEXIUM 40MG CAP	00186504031	INS.	5.09
293359		11/03/04	AMARAM, CHANDRAK	60	MEPROZINE	00603442421	INS.	1.72
293360		11/03/04	AMARAM, CHANDRAK	90	ALPRAZOLAM 1MG	59762372103	CASH	22.75
293993		11/12/04	BARANWALL, AKHIL	1	COMBIVENT INHALER 14.7GM	00597001314	INS.	3.43
294547		11/22/04	BIVINS, MARC H.	25	ENDOCET TABLETS 5/325	60951060285	INS.	.56
294548		11/22/04	BIVINS, MARC H.	30	LIPITOR 80MG TAB	00071015823	INS.	5.12
294549		11/22/04	BIVINS, MARC H.	30	PLAVIX 75M TAB	63653117101	INS.	5.97
294550		11/22/04	BIVINS, MARC H.	28	SPECTRACEF 200MG	67781018160	INS.	2.79
294551		11/22/04	BIVINS, MARC H.	5	ZITHROMAX 250MG TAB	00069306030	INS.	37.37
294552		11/22/04	EVANS, J.GARY	1	NOVOLOG MIX 70/30 10 ML	00169368512	INS.	55.23
294591		11/23/04	AMARAM, CHANDRAK	60	NEURONTIN 300MG CAP P-D	00071080524	INS.	15.00
							Totals:	2848.74

Authorized Pharmacist Signature: 


979 TEBEAU STREET
WAYCROSS, GA 315
Rx 287994
SHIRLEY GRI
TAKE 1 TABL
DAY.
30 BEXTRA
Dr.AMARAM


The Medic
TEBEAU STREET
AYCROSS, GA 31501
Rx 287994-t
SHIRLEY GRIFFIN
TAKE 1 TABLET
DAY.
30 BEXTRA 20MG
Dr.AMARAM

The Medicine
Pha
RPh#1
BEXTRA 20MG TA
DrugEmp